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ABSTRACT

This report documents the development of a two-pronged, model approach to early intervention with families in low-income communities. Since 1988, the Far West Laboratory's Center for Child and Family Studies and agencies in two low-income communities have been collaborating members of the Bay Area Early Intervention Program (BAEIP). BAEIP organizes agency services and develops new ones so as to create a coordinated support system that serves families from pregnancy through the child's eighth year. The program's intervention model consists of two interrelated efforts: the Augmented Family Advocacy System (AFAS) and the Community Services Support System (CSSS). AFAS uses a home-based, case management strategy to deal with program participants, while CSSS works with community institutions, informal networks, and service agencies to facilitate their coordination, collaboration, and support in providing assistance to families. In this report, information from the work done in the two low-income communities involved in BAEIP is used to illustrate the manner in which facilitation activities took place and the needs and issues that those who attempt similar interventions should expect to encounter. (RH)

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AUGMENTED FAMILY SUPPORT SYSTEMS

A Description of An Early Intervention Model For Family Support Services In Low Income Communities

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AUGMENTED FAMILY SUPPORT SYSTEMS

A Description of An Early Intervention Model For Family Support Services In Low Income Communities

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October 20, 1990

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ABSTRACT

This report documents the development of a model approach to early intervention with families in low-income communities. Since 1988, FWL's Center for Child and Family Studies and agencies in two low-income communities have been collaborating members of the Bay Area Early Intervention Program. BAEIP organizes existing agency services and develops new ones so as to create a coordinated support system that serves families from pregnancy through the child's eighth year.

The intervention model consists of two separate but interrelated efforts. The Augmented Family Advocacy System deals directly with program families, utilizing a home-based, case-management strategy. The Community Services Support System works directly with community institutions, informal networks and service agencies to facilitate their coordination, collaboration and mutual support in providing assistance to families.

INTRODUCTION

The purpose of this document is to present information on the facilitation of early intervention family support activities in low-income communities. A philosophy of intervention and a model for intervention activities are introduced. Specific information from work in two low income communities is used to illustrate the manner in which facilitation activities took place, and to present the common needs and issues that those seeking to attempt similar interventions should expect. The major focus of the document is to describe a two-pronged intervention model developed jointly by community members, and FWL staff. Over the last two years FWL and members of the two participating communities have been developing this two pronged intervention strategy and adapting it to the needs of both communities. One thing became quite clear during that time. The "process" of developing the model is a significant part of the model. That process is often what predicts successful implementation. Therefore this process of model development will also be described.

BACKGROUND

Since 1988, FWL's Center for Child and Family Studies and agencies in two low-income communities have been collaborating members of the Bay Area Early Intervention Program (BAEIP). Aware that the piecemeal work of multiple agencies cannot offer the comprehensive kinds of services needed by high risk young children and their families in such communities, BAEIP organizes existing agency services and develops new ones so as to create a coordinated support system that serves families from pregnancy through the child's eighth year. FWL participates in this work by facilitating inter-agency collaborations and providing training and technical assistance. We help communities not only to address practical family needs such as housing, nutrition and income, but also to promote positive family relationships, home environments and parenting skills. Services being designed are home-based and case-managed, and with special attention paid to healthy, drug-free fetal development and, later, to the provision of high-quality day care.

Working in these communities since 1988, FWL has come to understand that problems faced by both families and agencies are deeply woven into the fabric of daily life. No one agency working alone can make lasting change, nor can multiple institutions working in isolation from each other. Collaborative work, focused particularly on prevention, is crucial. To that end, FWL has taken on the role of community and systems change agent. Our approach is based on 20 years of implementing and studying early intervention projects.

The Communities

The two California communities in which BAEIP is operating are the Western Addition of San Francisco and Marin City. Both the Western Addition of San Francisco and Marin City have high rates of unemployment, particularly among young males; crime, much of which is drug-related; and teenage pregnancy. Residents are largely low-income minority families, most of them African American. For various reasons, the children and families in these communities are underserved.

According to 1985 U.S. census tract data, the Western Addition's mean family income is $14,315 - half the average family income for the entire city of San Francisco. Thirty percent of families live below the poverty level, and unemployment among those age 16 and older is 46 percent. About 31 percent of residents have not completed high school. Approximately 53 percent of families are African American; 84 percent are non-white. Forty-five percent of families are headed by a single mother, and nearly 61 percent of children live in female-headed households.

Marin City's socioeconomic profile is similar. In a county with one of the highest average household incomes in the nation, 36 percent of households in Marin City have incomes below the poverty line. It is estimated that 34 percent of adults are unemployed and that 36 percent of adults have not completed high school. As many as 50 percent of adults may be functionally illiterate, and one study indicated that about 41 percent of all residents lack the basic skills necessary for entry-level jobs. Approximately 75 percent of residents are African American, and almost two-thirds reside in public housing. Eighty-nine percent of families are headed by a single mother.

Program Goals

The BAEIP's major goal is to develop model comprehensive child and family support systems in low-income communities.

There are three specific programmatic goals:

1. To demonstrate how conceptual, programmatic, organizational and practical assistance can be provided to two low-income communities so that they can develop a coordinated, and comprehensive child and family service system (pregnancy through 2nd grade). The system will be created through new alignments of existing social service agencies, schools and other institutions;

2. To document: (a) the unique conceptual, programmatic and organizational structures developed, and (b) the facilitative process used to create the service system; and

3. To share this information throughout the Western Region and the nation, along with information about other models intended to develop child and family service systems through inter-agency cooperation.

THEORETICAL AND RESEARCH FOUNDATIONS

During the first year of operation a study of early intervention approaches and outcomes was conducted. The following information was shared with key actors in the participating communities and became the foundation for local design and planning activities.

The late 1960s and early 1970s saw a number of early intervention projects with minority families characterized at that time as "disadvantaged." (Lazar & Darlington, 1982; Provence & Naylor, 1983; Lally, Mangione, & Honig, 1988; Schweinhart & Weikart, 1980). Longitudinal findings from these studies showed that positive long-term outcomes are possible with early intervention. For example, program children exhibited fewer signs of failure in school than their controls. Moreover, attention to parent/child and caregiver/child relationships resulted in the children having more of a prosocial orientation in later years. In addition, program children experienced fewer and less severe encounters with the criminal justice system than their controls.
Equally important, early investigators were able to determine which particular intervention components and strategies were essential to their successes. Based on their experience, they also identified activities they would add to future interventions. Almost universal agreement has been reached among the scientists who participated in the early studies. They found that:

1. An "inoculation" approach to family support (early intervention followed by a complete cessation of services) was less helpful to the families and children than continued but less intensive supports (Zigler & Valentine, 1979); and

2. A small portion of the families served (10-20 percent) needed some type of psychotherapy or family counseling above and beyond the social or educational programs conducted (Zigler & Valentine, 1979).

After an extensive study of the early intervention literature, and interviews with many of the directors of successful early intervention programs, Schorr (1988) concluded:

> The programs that work best for children and families in high-risk environments typically offer comprehensive and intensive services. Whether they are part of the health, mental health, social service, or educational systems, they are able to respond flexibly to a wide variety of needs. In their wakes they often pull in other kinds of services, unrelated in narrowly bureaucratic terms but inseparable in the broad framework of human misery. These programs approach children not with

bureaucratic or professional blinders, but open-eyed to their needs in a family and community context. Interventions that are successful with high-risk populations all seem to have staffs with the time and skill to establish relationships based on mutual respect and trust. (p. xxii)

Lally and Mangione (1989) reported findings similar to Schorr's, adding the overwhelming need of program families for high quality childcare. At the 10-year follow-up, when parents were asked what was best about the Syracuse University Family Development Research Program, 79 percent said high quality childcare.

After studying early programs. Bronfenbrenner (Pence, 1988) uncovered three critical features of successful intervention programs:

1. The empowerment of those who are the intended beneficiaries of policy and practice, since they turn out to be the principal agents of change;

2. the importance of discovering and responding to the differing characteristics, needs and initiatives of program recipients, with the program itself behaving as a social organism, accommodating the families it serves; and

3. a recognition of the impact of perceptions, beliefs and meanings as well as of objectively identified conditions. events and processes.

Bronfenbrenner also emphasizes the importance of attention to developmental transitions.

> *Existing theory and research point to the importance for the child's development of the nature and strength of connections existing between the family and the various other settings that a young person enters during the first two decades of life. Of particular significance in this regard are the successive transitions into (and within) daycare, peer group, school and work. (Bronfenbrenner, 1986, p. 734)*

In her survey of research and treatment programs for children whose mothers used cocaine and other drugs during pregnancy, Kronstadt (1989) concludes that the incidence of drug use is so high in low-income communities, and the impact on parent/child relationships and child behavior and development are so great that early intervention programs with this population must include attention to these issues in their design.

The study of the early intervention field and the sharing of information about theory and practice with the collaborating communities led to the development of working assumptions upon which the local interventions are based. After local deliberation, a

philosophy of intervention was developed that was thought would best serve all concerned. The following philosophical foundations for the work were developed and have been agreed upon by FWL and representatives from the two program communities.

WORKING ASSUMPTIONS

General Assumptions

1. An early intervention program should be designed not as an inoculation but as a first step in a continuing and comprehensive system of supports.

2. Early intervention efforts should take place with and through already existing agencies in the community served rather than stand alone; and in addition to individuals and families, service systems should be the focus of the intervention.

3. Partnerships with schools that will eventually serve program children should be established well before children reach the school door.

Assumptions Related to Early Intervention Philosophy

1. To maximize educational and social benefits, intervention should be started early with particular attention paid to the development of the fetus in a drug free and healthy womb and to the quality of childcare services provided.

2. Effective early intervention calls for establishing a personal relationship between a member(s) of the early enrichment team and the families served, particularly the principal caregivers of the program children. A case manager, home-based service system is well suited for ensuring the establishment of a personal relationship.

3. A non-judgmental analysis of family strengths and practical needs (i.e., nutrition, childcare, housing, finances) should form the basis of individualized intervention strategies for families. This intervention must include needed therapeutic services.

4. High quality childcare services must be made available to families served.

5. Special attention has to be paid to "life cycle transitions" the family goes through as a child matures.

Specific Issues Identified

In addition to developing an intervention philosophy, specific issues were identified which community members decided must be handled through the practice of that intervention philosophy. The strategic issue addressed by BAEIP is inter-agency collaboration for the provision of preventive services for children and families with multiple needs. Specific issues identified by the communities as needing special attention are:

1. The coordination of agencies and institutions serving low-income, multi-problem families with target children starting at pregnancy and lasting to third grade;
2. family support services;
3. general child rearing/parenting;
4. family substance abuse and its effect on child rearing and schooling;
5. infant, toddler and preschool childcare, early childhood education;
6. transition of at-risk children/families from community services to school services;
7. development of a family-focused, case management approach to at-risk children and families; and
8. prevention of school failure, special education placement, and anti-social behavior.

GENERAL INTERVENTION APPROACH

Young children and their families are dramatically affected by conditions and events that take place not only within the home but also within the broader contexts in which family life is embedded. Individual change must be accompanied by contextual change if the changes are to be more than temporary. This means that if an intervention approach focuses on only the home or on only the larger context in which the home is situated, the intervention will be incomplete.

To address this possible intervention shortcoming, BAEIP has designed a two-pronged intervention strategy. The first prong, **The Augmented Family Advocacy System**, is designed to deal directly with program families, using a case management system to identify and meet individual child and family needs. This aspect of the intervention attends to the particular needs of the family: parent/child relations, other family relations, and to family relationships with the various informal neighborhood and community networks and service agencies they need to deal with to function effectively.

A second prong, the **Community Services Support System**, deals directly with those informal networks and service agencies. It is designed to develop long-term changes in the quality of family life in communities served. Agencies that serve program families are brought into collaborative working agreements with BAEIP and participate in the design and

implementation of a long-term service strategy for program families. Informal neighborhood and community networks are identified, enlisted, and facilitated in their support of program families. The "**Community Services Support System**" focuses on upgrading and expanding services as well as establishing and maintaining collaborative relationships among informal networks and service agencies.

Our strategy for work in the area of family transitions can be used as an example of this two pronged approach. It is clear that benefits gained by children and families often get lost as a child and family make a transition from one social or community system to another. When a child moves from care in their home to care in an infant center, to Head Start, and to school, the rules of appropriate action change, as do the rules for the adult family members as they relate to these and all the other social and community systems they must deal with as the child grows. The larger context influences the quality of this social experience and contributes to positive or negative experiences. For minority children, it may mean encountering children from other cultural groups for the first time or it may mean becoming more socially competent in a culturally homogenous context. Either one of these conditions is going to require different adaptations on the part of the children. To influence adaptations in a particular cultural group, it is necessary to influence both the developmental aspect of the transition and the context for the transition. Thus, in this intervention model both individual/familial and system issues are addressed. Direct assistance is provided to the program families through case managed family advocates. At the same time direct assistance is provided to the social and community systems to help them adapt their policies and practices to deal with issues such as "developmental transitions" through the development of a special consultant pool. This is but one of many areas that could be cited as an example of simultaneous intervention into family systems, and social and community systems. The two pronged intervention strategy developed as part of BAEIP is presented below.

ORGANIZATION OF TWO-PRONGED INTERVENTION

The dual support to families and community services is managed by a coordinating agency. This agency employs a **Program Facilitation Group** and arranges for assistance from a **Special Services Consultant Pool**. Both the Program Facilitation Group and the Consultant Pool provide specialized support to case managers and family advocates who in turn have direct contact with families. The kind of support the case managers and family advocates receive includes expert assistance with issues such as infant health and nutrition, child development, substance abuse counseling for parents, child care, and employment training for parents. The kind of support the community's service providers receive from the Program Facilitation Group and the Consultant Pool include staff training and technical assistance. Thus, a key indirect link between the families and the community services is established through the coordinating agency's Program Facilitation Group and Consultant Pool. Of course, the direct connection between the families and the community services is maintained through the services provided by community agencies to the families. The

indirect link between services and families is a crucial feature of the intervention model because it creates an information channel that enables community agencies to adapt their direct services to the changing needs of developing families. Although both prongs of the intervention are presented below separately, they are closely related to each other.

PRONG I: AUGMENTED FAMILY ADVOCACY SYSTEM

The unifying concepts of the **Augmented Family Advocacy System** are support and coordination. Each participant in the intervention (members of the families and community, members of the program staff, and personnel in the service agencies) are looked upon as special resources to one another who can contribute to the quality of life of the family. Communication and coordination among these resources will make the intervention function effectively.

The approach contains the following key elements:

1. The establishment of personal relationships between program staff and families.

   Honest, trusting, dependable relationships with effective people who are understanding, friendly and helpful are the key to family interventions.

2. The use of community resources and professional staff.

   Family interventions that are part of the communities served have a greater chance of having a lasting impact on the community, being integrated into ongoing community services after intervention ceases and of being truly responsive to community needs.

3. The establishment of a strong link between the family and the formal community services. This link will enable families to fully utilize services available to them as well as help service agencies be responsive to the individual concerns and needs of each family.

4. The establishment of a strong link between the family and networks of informal support in the community. Efforts will be made to help the families expand their social networks so they can turn to friends, neighbors, and other families in the community for support. Child care, temporary respite, emergency services and help with unique problems are important issues to families that can be met either formally or informally, but need to be met.

5. The establishment of high level and wide ranging professional supports. The community-based staff will have primary responsibility for direct contact with families; they will be backed up by specialists who will be available for consultation and when warranted, direct service to families.

To insure that the program-family relationship will be personal, three criteria have been established in designing this intervention. First of all, only a small number of program staff (two) will have direct, ongoing contact with a family. This will allow the family to get to know the people they deal with rather than their having to keep getting to know one stranger from the program after another. Secondly, the program staff who establish the relationship with the family will have firsthand understanding of the life experiences of the family; they will be closely connected to the community, most often a member of the community. And thirdly, there will be a high degree of contact with the family. This will be accomplished through weekly home visits by the same program staff members over the course of several years.

The two program staff who will be responsible for establishing the relationship with the family are the Case Manager and the Family Advocate. The Case Manager, a community-based human services professional with experience in child and family development and home visitation, will make the first contact with the family. Once the concerns and needs of the family are assessed by the Case Manager, a specially trained Family Advocate, also a member of the community, will be introduced to the family. The Family Advocates will visit the family and consult with the Case Manager on a weekly basis. They will provide basic information to families in such areas as child development, the nutrition and health needs of young children, and resources and services in the community; help families build their informal social networks in the community; and link the families to community services. The Case Manager will continue to visit the family on an occasional basis and will at all times be available to the family if a special need arises. In addition, the Case Manager will provide daily supervision to Family Advocates, conduct weekly inservice case conferences, and coordinate weekly Family Advocate trainings. By having differing levels of contact with each family, the Case Manager and the Family Advocate can become sources of mutual support to one another, each having a unique perspective and understanding of the family.

The families to be served will have specialized needs. The Case Manager and the Family Advocate will provide general support to each family, and link the family to specific services as well. In a small number of special cases when intensive therapeutic intervention is judged necessary, an Infant/Parent Therapist will be assigned to the family rather than a Family Advocate. In all cases, an Augmented Family Advocate System will support the efforts of the Case Manager to link the family to appropriate services. In other words, the general, personalized support of the Case Managers/Family Advocates will be balanced by specialized, coordinated, usually more distant support of the Augmented Family Advocate System (See Figure 1). As stated earlier, the indirect support to families is accomplished through the intervention's Program Facilitation Group and the Consultant Pool. The

intervention's coordinating agency also employs an Intervention Director, who is responsible for supervising the Case Managers and Family Advocates and coordinating the activity of the Program Facilitation Group/Consultant Pool in relation to the efforts of the Case Managers/Family Advocates. Figure 1 shows the organization of the Augmented Family Advocate System. Each staff role listed in Figure 1 is explained following the figure.

AUGMENTED FAMILY ADVOCACY SYSTEM

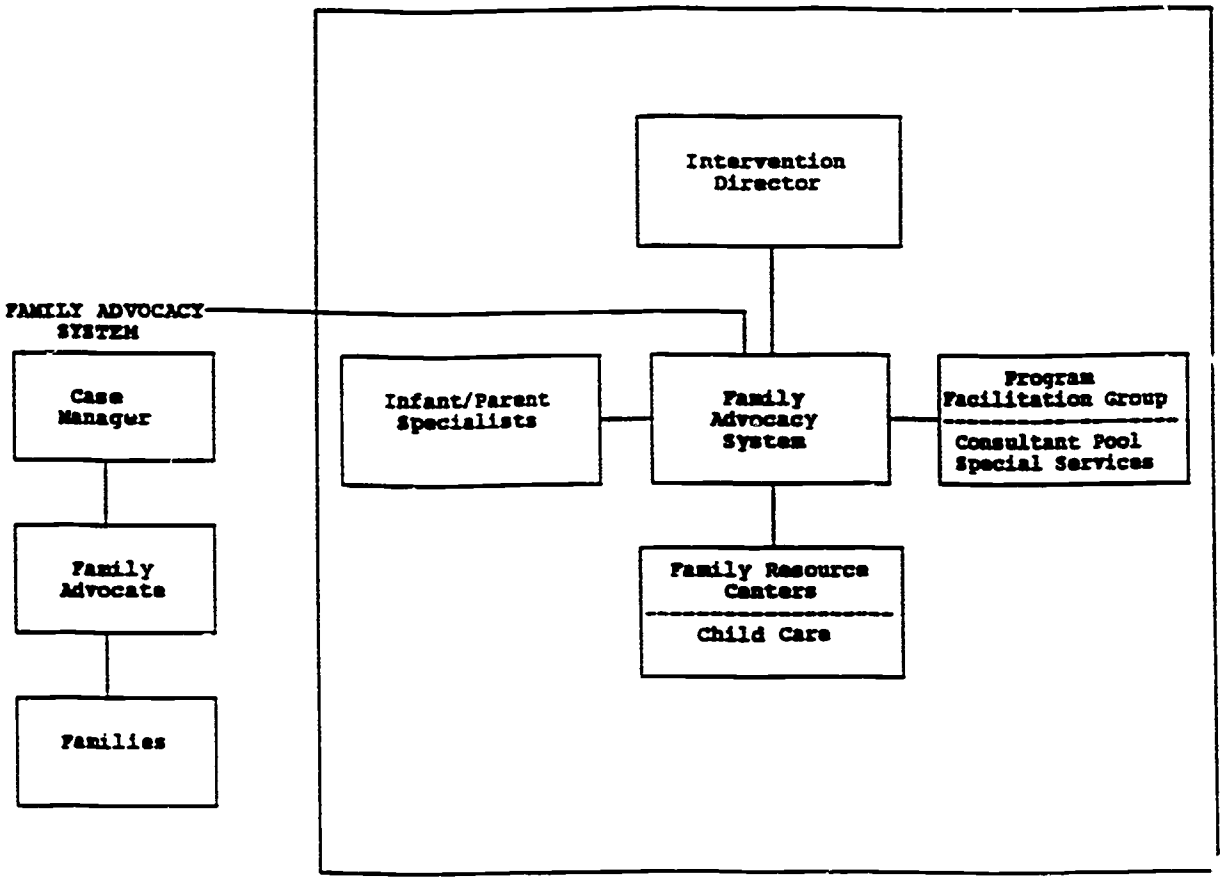

FIGURE 1

Family Advocate

The Family Advocate is the key service provider in the BAEIP model. Through weekly meetings with family members the Family Advocate is the access point of community services for each family. The Family Advocate has a specific and direct role as a broker of available family services. This role consists of ongoing discussions and the identification of family needs. The Family Advocate helps clients to identify agencies who provide needed services. The Family Advocate assists families by encouraging successful approaches to obtain needed services.

This home-based worker has a dual role with the families:

(1) delivering parenting and child development information; and
(2) helping families assess needs and providing linkage with other services.

The Family Advocate provides families with information about child development, parenting, health, and will include information on anticipated developmental progressions, common issues in parent-child relationships, health, safety, and nutrition. Examples of the type of work they are expected to do during visits made in the first year of life is presented below.

A prenatal contact:

1. To create a group of family members and supportive adults to share the pregnancy and birth experience with the mother.

2. To provide an opportunity for the prospective parents to discuss the upcoming birth and parenting role with counselors and with other parents both with and without records of abuse and neglect.

3. To evaluate the home environment and family dynamics and to begin to individualize the interventions based on those dynamics.

4. To facilitate contact with the institutions and individual professionals that will assist the family through an optimal bonding birth experience.

5. To provide the opportunity for individual counseling, i.e., nutrition, drug, psychological, etc.

6. To have parents learn the importance of drug free pregnancy and to enlist in detoxification programs those addicted.

Early Contact at Home (first six months of life)

Home visitation and therapeutic intervention with attention paid to the affective quality of parent/newborn interactions, with particular attention to:

responsiveness to infant crying
responsiveness to infant signals related to feeding
caregiver facial expressions that show appropriate responsiveness to infant cues
understanding of temperament
holding of the child in a tender and careful way
playfulness of caregiver with infant
type of physical contact during feeding
adjustment of other family members
shifts in family dynamics
provision of medical care
continued support and expansion of services based on shifting needs

and to the parents' attitudes for indications of possible warning signals:

complaints of inadequacy as parent
complaints of inadequacy of child
fear of "doing something wrong"
attribution of malevolence to the newborn
strong psychological link to their past destructive childhood
(identification with aggressor and peer jealously)
misdirected anger
continued evidence of isolation, apathy, anger, frustration, projection
adult conflict

Attention is also paid to services needed immediately, both situational (economics, child care, danger, etc.) and unmet emotional needs and education:

sharing of information about hot lines, warm lines, babysitters, child care, etc.
developmental abilities and inclinations of the newborn
child care and home management
establishment of informal and formal network contracts

The Family Advocates should be trained to become sensitive and skilled observers of young children and to use this skill to help parents become more keenly aware of specific aspects of development and more capable of engaging in informed discussions of child-rearing issues and of identifying particular areas of concern.

Case Manager

The case management system has been designed to maximize continuity of service over the duration of the project as well as to insure early identification of the most pertinent family and child needs. A computerized data collection and retrieval system is suggested for the ongoing collection of data, for the monitoring of information, and for the development of reports. This system allows the case manager to be up to date with each case and to use the supervision time with family advocates in a productive way. This system should also assure confidentiality of family information.

The Case Manager responsibilities include:

1. Initial assessment of children and family done in home or center.

2. Assignment of families by Case Manager to specific Family Advocates and transition of the case to that worker.

3. Weekly review of all case records and contacts.

4. Weekly meetings with each family advocate in which assigned cases are reviewed and specific steps are planned. A family assessment, and individual service plans will be used as guides in this process.

5. The maintenance of contact with other social service and educational agencies that are involved with the family directly or through the Family Advocate.

6. Periodic update of individual service plans and assessment data.

7. As needed, the Case Manager will facilitate community case conferences for a specific family who is involved with multiple agencies for the purpose of coordination of services. These conferences will also have as a secondary purpose the building of linkages and effective working relationships with participating agencies. These community case conferences should be seen by the Case Manager as useful in providing indirect training in supportive family and child development work in each community.

All Case Managers are to participate in a weekly consultation group with a highly skilled therapeutic infant-parent program specialist to receive supervision and support in providing therapeutic intervention services. They are also expected to work closely with the Intervention Director to assure that the special therapeutic needs of families are met.

Intervention Director

The Intervention Director is designated as the primary resource person. The assignment involves regular contact with clients and staff at the intervention site and participation as facilitator for site trainings. It also includes responsibility for linkage and coordination with agencies from the site neighborhood who are participating in training or technical assistance efforts. A major responsibility is the selection of appropriate Program Facilitation Group members and Consultant Pool members for needed on-site training and technical assistance. The Intervention Director is the communities major link to support services. Additionally he or she is the point of contact for the case managers, acting as a broker to help them identify other resources on the training team and in the community as necessary. Each should be a highly skilled consultant and trainer with expertise in working with a variety of agencies. They must also be generally knowledgeable about intervention programs, staff dynamics, and child and family development. Well developed time management skills and experience handling a variety of roles are important.

The Intervention Director is responsible for conducting site trainings, providing technical assistance, trouble shooting for the Case Managers and enlisting the members of the Program Facilitation Group and the Consultant Pool to meet the special needs of the program families, case managers, family advocates, the staffs of the child care services and drop-in facilities and other members of the program community in need of services. In effect, they collaborate with the Case Managers in setting up an individualized plan of coordinated services for each family.

The Intervention Director will:

(1) provide ongoing support to the Case Manager;

(2) organize/facilitate the weekly in-service meetings at each site;

(3) work closely with the Case Manager in a collaborative manner to solve problems as they arise;

(4) assist in identifying and building relationships with resource and core services;

(5) support the Case Manager in facilitating case reviews;

(6) develop in-service training content pertinent to the specific needs of the site staff; and

(7) ensure that program operations on site are consistent with the mission and purpose of the program and of sufficient quality to meet program objectives.

Program Facilitation Group and The Consultant Pool

The Program Facilitation Group supports the two prongs of the program's intervention. This means supporting Family Advocates, who establish personal and ongoing relationships with families, with powerful back-up services. The Program Facilitation Group should be part time (10% to 25%) salaried employees of the program, available for training, consultation and planning. Each team member has a primary content area responsibility for the delivery of specific programmatic expertise to both staff and participating agencies. Each group member should be knowledgeable and able to work in a general way with all staff in terms of the overall goals of the program as well as to be able to specialize in a particular area. In addition to programmatic expertise and a broad knowledge of intervention programs, each group member should have a particular specialty as well as professional networks and connections to others working in their field. Areas of expertise that should be included are:

Job Development Specialist
Resource/Organizational Development Specialist
Special Education Specialist
Substance Abuse Specialist
Perinatal Specialist
Infant Care Specialist
Pediatric Nurse Practitioner
Parent Education, Child Development
Teen Parenting Specialist
Maternal/Child Health Educators

The Program Facilitation Group is specifically responsible for meeting the training and technical assistance needs of case managers and family advocates and for making special home visits with Family Advocates.

The Consultant Pool consists of specially selected individuals who are called upon to meet unique family and community needs on demand. They are all to receive program orientation and to be familiar with program goals and philosophy.

KEY SERVICE COMPONENTS

As an augmentation to the case managed family support activities it was decided that certain kinds and styles of services should be an integral part of the intervention. These service components are described below.

Home Visitation

Home visitation is weekly, and the content of the home visitations is individualized. Individualization of content is discussed during the weekly meetings with case manager and the family advocates. In addition, family advocates are to respond flexibly to family situations and adjust any planned content as needed. The individualization of content comes from three sources:

(1) Families self identified needs, questions and concerns,
(2) Assessed needs of child and family which may or may not be congruent with the families own concerns, and
(3) Information in a core curriculum.

Each family participates in writing a plan which outlines in a direct manner specific areas of concern to be covered on the home visits and in other activities in the program. Services that the family need are developed into an outlined plan. An important part of home visitation is the development of this Individual Family Plan. This plan serves as a guide for the families and the family advocates as to their activities in each quarterly period. The plan provides a concrete way in which the family can take credit for accomplishments such as successful entry into a job training program, weaning of a child, or location of a better housing situation.

Family Resource Center

The Family Resource Center provides a variety of resources and services to the families including a drop-in center. It is a place where the families can go and shape their relationship with the intervention program in a way that best meets their needs.

The Family Resource Center should be seen as the visible center of intervention activities. Staff of the program are to be housed here. The Center should be located in target neighborhoods near high concentrations of eligible families.

Each center should include:

(1) Offices for the Case Manager and Family Advocates.

(2) Meeting rooms where families can meet privately with program staff or service providers from other agencies. The family meeting room should have a local telephone line and computer terminal with a data base of community resource information to allow families and staff to work together to research a needed resource.

(3) Space suitable for group meeting and training for families, staff, and participating community agencies.

(4) A comfortable and attractive area for parents and children: to include seating areas, play space, and toys for the children, bulletin boards with community information, a toy and equipment lending library, restrooms, and changing facilities for infants.

(5) A limited number of drop-in child care slots in community day care centers and homes that would be made available for families who need time at the center for work with their Family Advocate, for special services, or for group activities.

Child Care Services

High quality child care is a key element for successful early intervention. Therefore, a primary service to be made available for families is comprehensive child care.

Relationships must be established and cooperative agreements made with specific centers and family-based programs for infant/toddler, preschool and school-age care in the community. Infant-Toddler (center and family day), Preschool, and HeadStart child care services should be enlisted into the intervention community served.

It is recommended that the facilitator, in this case FWL, provide special training to all the child care facilities. For example, in BAEIP FWL will use its nationally recognized video training package the "Program for Infant-Toddler Caregivers" and its "Responsive Education Curriculum" for this training. Programs should also provide special consultation through the consultant pool on such topics as integration of special needs children, care of children whose mothers were addicted to drugs during pregnancy and other special topics.

To assure high quality child care, the program should work closely with directors, teachers, and family day care providers to strengthen and improve programmatic and service delivery aspects of the centers/homes, such as:

(1) classroom/home management,
(2) caregiver-child interpersonal relations,
(3) curriculum (IEPs and general early childhood developmental appropriateness)
(4) classroom/home environments,
(5) family/parent/provider relations, and
(6) work climates and supervision approaches that support ongoing professional development.

Family Advocates and Case Managers are to work closely with families and child care providers to find quality child care matched to family and child needs.

Family Fund

A special feature of this intervention is the Family Fund. This fund of $1000 per family is to be used to purchase services that cannot be provided directly by either by the BAEIP or any of the collaborating Agencies. This money is to obtain or facilitate the use of any special services that might be identified by the family and the Family Advocate. Family members and the case manager are to meet quarterly to review this plan.

These funds are to be administered by the Case Manager in consultation with the Intervention Director and based on the Individual Family Plan. This approach insures the project the ability to make some support service decisions as needs arise, rather than be forced to predict them as most early intervention efforts are expected to do. This fund very clearly reflects the type of dynamic approach to family support which Bronfenbrenner recommends.

Infant-Parent Therapy

In accord with Zigler and Valentine (1979) findings on the need for more intensive services such as psychotherapy or specialized counseling in addition to the usual education and support services, the BAEIP recommends use of a variety of strategies to address families' needs for specialized services. As part of early intervention an Infant/Parent Therapist available to make home visits is to work directly with program families in need of therapeutic intervention who cannot be placed with collaborating agencies.

Special Services

Special services such as drug treatment, counseling, family therapy or individual therapy should be arranged with appropriate agencies or individual service providers. Family Advocates are to assist families in finding funding for these services. Monies from the family's individual fund might be used to supplement costs or use of these services. While the special services are provided, the case management and home visiting approaches are to integrate these services into the Individual Family Plan.

PRONG TWO: COMMUNITY SERVICES SUPPORT SYSTEM

In support of the work being done in **PRONG ONE** with individual families, a second intervention component, **PRONG TWO,** directly serves and facilitates the work of those service agencies, institutions and neighborhood networks that influence the lives of program families both directly and indirectly.

Much has been made about the need for coordination of family services, social service budget deficits, service gaps, and the like when it comes to really helping families develop. Also of great concern to those hoping to influence families positively is the power of informal networks to either support or weaken a family's functioning. A family either isolated from positive informal networks or participating in maladaptive networks will have trouble functioning. Our two pronged intervention strategy recommends that intervention staff analyze, supplement, and orchestrate the services of agencies and institutions already serving families in the program communities. For example, in Marin City a study of the scope of work of all social service agencies providing services in Marin City is being conducted for the purpose of uncovering overlap, conflicting messages to families, fiscal efficiency and impact on families.

Integration of the research community with schools, other social service agencies, private organizations, community groups and family members is repeatedly called for as a necessary response to the problems of at-risk children and families (Schorr, 1988; Slavin, et al., 1989). To carry out such integration, FWL is facilitating the efforts of community organizations to develop, provide, and evaluate new systems and services for dealing with these issues. A crucial part of this work has been the shaping of the second prong of the two-pronged early intervention model that PAEIP has developed over the past two-and-a-half years. That approach is explained hei

THE AGENCY SUPPORT TRAINING AND TECHNICAL ASSISTANCE PROCESS

Initial Activity

It is recommended that community agencies be asked to participate in an initial evaluation process assessing current quality indicators and identifying those areas in which they would like to receive technical assistance and training. This evaluation is to be "agency directed" and include a number of critical areas: staffing patterns, staff-consumer interaction, work climate, organization goals, procedures, methods, and regulations. The evaluation should include feedback from families who receive services from the agency, providing a "consumer satisfaction" focus for program modifications. A need for increased coordination of services among different community agencies is to be addressed in this evaluation. Common needs among services provider agencies are to be sought and plans, if any, to provide coordinated services to the families served critiqued.

Program Development

Both interagency and intra-agency technical assistance and training should be designed to assist agencies in program and professional development. As in the family intervention approach, agencies will collaborate with program staff in the design and planning of training, and the technical assistance focusing on their programs' needs. An individualized approach based on particular needs identified and the operational systems of the agency is recommended. Program staff is to work with agencies to assess available resources, i.e., use of community development technical assistance agencies, recommend courses for staff, etc.

Networking

It is recommended that networking strategies focus on those agencies and informal networks that influence the lives of program families and life in general in the community served. Work with agencies and institutions should commence before the program families arrive at their doorstep. Networking efforts should prepare those agencies and institutions for service to the program families. Networking activities are to take place at every point in a target child's journey from infancy to school, with particular attention paid to the developmental transitions that take place as the child moves through life. Training, technical assistance, and organizational development help are to be provided in addition to direct service. The goal of this approach is to strengthen and supplement those services before and during the time program families receive service, and to alter the agencies' service approach from that point forward toward similar families who seek service.

The coordination of family resources, and interagency problem solving are addressed through networking approaches. As part of developing more permanent networks it is suggested that the organization of a **Family Support Services Coordinating Council** take place. This program-wide networking system can become a major element in the agency intervention process.

The agencies that are part of this group are able to identify common needs and goals, develop joint strategies to achieve the goals, establish linkages, and develop ways to coordinate services. In addition, agencies who have addressed particular areas of concern and who have developed expertise, can serve as resources, share information and methodologies with those who are seeking solutions. It is expected that this Council will develop collaborative funding proposals for joint services and engage in policy development.

Professional Development

A primary goal of any early intervention program should be to expand the field of family development/support professionals within the community served. A development plan for this purpose is recommended. The plan developed at BAEIP is described below:

1. Ongoing professional development program for the Family Advocates. An intensive orientation and staff preparation program should be implemented within the start-up phase of the project. A 12-15 unit program is recommended for this initial phase of training.

2. During the first two years of the project, a certificate for practitioners working with infants and toddlers in childcare programs, and other family focused agencies, i.e., health, mental health, etc., should be designed. For example, BAEIP is working with the California State Department of Education to jointly offer the Certificate. It is recommended that this Certificate be made available in subsequent years to community agencies wishing to train and prepare staff for family intervention. The certificate is to provide for professional recognition of entry level practitioners working with families.

3. Identify existing and develop additional training opportunities for Case Managers and Family Advocates to continue with undergraduate and graduate work in the field of human services and family development related fields.

4. Develop long range career development plans. For example, BAEIP is exploring during the first five years of operation to work with a local educational institution to initiate a combination MS Ed/MSW degree with a focus on child/family care and support.

Agency Support: Training and Technical Assistance

The Program Facilitation Group and the Consultant Pool play a major role in this activity. Under the direction of the Intervention Director training and technical assistance in efficient agency functioning and strategies for collaboration are provided. Specifically, an agency support process is to function concurrently with the family support and intervention process. This type of support is designed to assist provider agencies with ongoing technical assistance and training issues. Some of the activities to be conducted are:

Quality Control and Program Enhancement (The strengthening of services delivered to program children);

- o Staff development (staff competency as related to program achievement goals)
- o Program development
- o Organizational development
- o Other (as indicated by individual agencies)

Resource Development and Expansion of Services:

- o Proposal development
- o Assistance in long range planning

Collaboration:

- o Better coordination of services
- o Resource sharing
- o Collaborative proposal development
- o Joint planning

Local policy development:

- o Orientation of Community to Augmented Family Advocacy approach
- o Dissemination of a "Community Family Service Plan"

Redesign of Family Services

A critical part of **PRONG TWO** work is the facilitation of redesign activities. Staff should conduct and coordinate this activity with the assistance of the Program Facilitation Group and the Consultant Pool. Community redesign activities should have specific focus on the area of family services. Working directly with schools, service agencies, community groups, and formal and informal networks, staff are to assist community leaders to develop strategies and plan for the implementation of a community wide family service system. The program families served are to be used as the focus for this system redesign activity. Using the target child in the program families as magnet for concern, redesign activities will commence related to perinatal and early infancy issues and should be developmental in nature.

Issues relating to the service of specific program families are to be used as "content" and/or "jumping off point" for redesign discussions. Issues that arise will be spotlighted for special concern by the community planners. As the target child grows, the redesign issues will change until by the end of five years a comprehensive family service redesign effort will have been conducted. It is recommended that the "Living Systems" analysis and redesign system be employed. Emphasis is placed on the documentation of these efforts to transform and to orchestrate community services so that the techniques can be duplicated at other sites. Documentation and evaluation of these efforts are seen as an integral part of the intervention.

THE LESSONS OF FACILITATING COLLABORATIVE COMMUNITY ACTIVITY

The experiences FWL staff have had over the past three years in both program communities have pointed to the crucial need for collaboration in both funding and operation of family support services. FWL has seen that without collaboration it would be impossible to fund and operate all the components of the planned intervention. Therefore a good deal of our work has been to act as catalyst for collaboration. This important insight was only one of the lessons we learned from our facilitation experiences. With the hope that by sharing some of our experiences with the readers will assist them in their efforts, we present this concluding section on lessons learned.

All throughout the BAEIP collaboration, a great deal of attention has been paid to moving slowly in communities so that ownership and initiation of activities take place in the communities rather than through the replication of model programs and activities. Even though FWL was invited into the communities because of the experience of running the Syracuse University Research Project and that it was the results of our work on the Syracuse Project that gained us credibility in the program communities, a replication effort was not seen as appropriate either by the communities or FWL staff. Additionally, funding emergencies experienced by the communities were responded to by the facilitating agency, FWL. Help in staffing, training and environmental renovations was provided by FWL for two reasons: 1) to maintain the quality of experience for children at a relatively high level; and 2) to show our responsiveness to the emergency needs of the communities that we hope to collaborate with over the long run. Some of the other lessons we learned are more specific in nature. The following list represents the major learnings stemming from this three-year effort.

- Forming collaborative relationships in at-risk communities requires time and patience. Because every participating agency and group influences the development of the intervention, negotiation must occur. Often the collaborative network is fragile, especially with respect to the issues of resources. Coalitions between communities and community agencies can easily break down when decisions must be reached about the allocation of resources. Open dialogue about community needs, fiscal constraints, and strategies for developing and sharing resources is vital at the formative stage of a collaboration.

- One of the challenges is to anticipate fiscal emergencies in the intervention communities and try to help key service agencies through their most difficult times. The communities in need of comprehensive early intervention programs are by their very nature underserved. Resources and services are normally stretched as far as they will go. There is no reserve for sudden

budget reductions or increased demand for services. Without support during rough times, such communities will have to attend strictly to the emergency at hand. This necessary survival strategy is disruptive and can undermine the long range planning process for improved early intervention services.

- Because of their vulnerable fiscal conditions, community service providers are reluctant to enter in a collaboration unless they can see that resource development is an integral part of the planning process. Thus, resource development should be built into the initial phase of planning.

- There is a strong consensus within the BAEIP network that early intervention should provide direct service to the families, and, to sustain the positive effects of the work with the families, change in the community, particularly in the community services, should be facilitated as well.

- Although long range change may be the primary goal of an early intervention program, short term outcomes and changes in services are important. A community may have pressing needs that call for immediate attention. Giving some attention to specific problem areas before large scale changes in services can be achieved may often be appropriate.

- Each agency has to be involved in the decision-making process. The facilitating agency in an early intervention collaboration must recognize that every constituency in the community has something to offer to the planning process. The process of introducing an early intervention in a community is not a matter of convincing the community to adopt an intervention model. The process is rather a matter of creatively adapting the model to the community through negotiation and consensus building.

- Because community services are usually stretched to their limit and have little or no time to handle procedural arrangements, the facilitating agency has to assume the role of providing ongoing logistical support. Managing the flow of communication and scheduling key events and meetings are essential functions in the operation of an intervention network.

- The single largest barrier to the development of early intervention services in Marin City and the Western Addition was fiscal in nature. Without resources, the strategies developed by BAEIP simply could not be implemented.

- An issue related to limited financial resources is the fragmentation of services in communities like Marin City and the Western Addition. The service providers are accustomed to working alone, and it is difficult for them to enter into collaborative relationships.

- Pressing crises and emergencies take the attention of the community away from the process of developing collaborative services. This factor delays, disrupts, and may even threaten the planning process.

- Because families in low-income communities are chronically underserved, they tend not to trust that early intervention services will ever meet their needs. This factor makes it difficult to gain the involvement of the community in the early intervention effort, yet community involvement is vital to the success of the intervention.

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Appendix 16

END

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